SWEDISH

使用、披露和发布受保护健康信息授权书
AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION (CHINESE SIMPLIFIED)

我了解以下内容：
I understand the following:

- 我有权拒绝签署此披露或发布我的受保护信息的授权书。拒绝签署此授权书不会影响我接受医疗保健服务或偿付服务的能力。拒绝签署此授权书可能影响我接受医疗保健服务能力的唯一情况为：医疗保健服务与研究相关，或仅向某人提供健康信息，此时，必须具备授权书以披露信息。

  I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

- 此请求可能会产生费用。There may be a fee associated with this request.

- 根据此授权书已使用的或披露的信息可能被再次披露且不再受联邦法律保护。但是，我也了解，联邦或州法律可能限制再次披露 **HIV/AIDS**、心理健康信息、基因测试信息和药物/酒精诊断、治疗或转介信息

  Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

- 我有权获得一份签署的授权书。 I have the right to receive a copy of this signed authorization.

- 我可以在任何时间以书面形式撤回此授权书。如果我撤回此授权书，则以下所述信息可能不再适用或不再出于此书面授权书所述之目的进行披露。唯一例外情况为：**Swedish** 已根据此授权书采取措施或将此授权书作为提供保险承保的条件。

  I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when Swedish has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

请向其中一个地点提交或撤销此授权书，具体取决于您接受服务的地点：
Please submit this authorization or revocation to one of these locations, depending on where you received care:

Swedish Medical Center	**Swedish Medical Group**
Release of Information Department 747 Broadway, Seattle, WA 98122 传真/Fax: (206) 320-2626 电子邮件/Email: ROI@swedish.org	电话/Phone: (206) 320-3025 传真/Fax: (478) 238-9436 电子邮件/Email: smgroi-wa@cioxhealth.com

重要事项：除非有开具账单的必要，否则 **Swedish** 不再打印或发布患者的社会保险号。然而，社会保险号可能包含于若干年前的患者信息中。您授权使用的信息可能包括您的社会保险号。

Important: Swedish no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

本机构、其员工、官员和医师据此免于承担因披露以上信息（在此授权书指定和授权的范围内）而产生的任何法律责任。

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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Swedish Health Services 及其附属机构不会以种族、肤色、原国籍、性别、年龄或残疾状况而在他们的健康计划和活动中歧视任何人。 Swedish Health Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

请注意：如果您不会说英语，您可以使用免费的翻译服务。请致电（888）311-9127（TTY：711）。
ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (TTY: 711).

我授权 Swedish 使用和披露以下具体健康信息：
I authorize Swedish to use and disclose a copy of the specific health information described below regarding:

患者姓名/Patient's Name _____ **出生日期/**DOB: _____

患者住址/Patient's Address: _____ **电话**/Phone: _____

城市/City: _____ **州/**State: _____ **邮政编码/**Zip Code: _____

接收披露信息方： To be disclosed to: ☐ **自己** Self **或接收者姓名：** Or Recipient's Name: _____

接收者住址： Recipient's Address: _____

城市/City: _____ **州/**State: _____ **电子邮件/**Zip Code: _____

电话/Phone: _____ **传真**/Fax: _____ **ኢሜይል፡**/Email: _____

请通过以下方式发送我的记录： Please send my records via: ☐ **MyChart** MyChart ☐ **电子邮件** Email ☐ **磁盘** Disc ☐ **纸质** Paper ☐ **传真** Fax

我希望从以下机构索求信息： I am requesting information from the following facility(s):

医院名称（清单）和电话号码 Hospital Name (List) & Phone Number	诊所名称（清单）和电话号码 Clinic Name (List) & Phone Number

使用日期从： For the range of dates from: _____ **至：** to: _____

用于以下诊断或伤害的相关信息： For information related to the following diagnosis or injury: _____

需披露的信息有/Information to be disclosed:

☐**病史及体检记录/**History & Physical

☐**手术记录/**Operative Report

☐**诊断报告（实验室化验、x 光、EKG 等）**
Diagnostic Reports (lab, x-ray, EKG, etc.)

☐**其他（详细说明）/**Other (specify): _____

☐**出院小结/**Discharge Summary

☐**急诊科记录/**Emergency Department Report

☐**进展记录/**Progress Notes

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使用目的：_____
For the purpose of:

除撤回外，此授权书有效期为 **180** 天或在此日期失效：_____
Unless revoked, this authorization expires in 180 days or on this Date:

条款：除非我本人以书面形式对此授权书进行限制，否则，此授权书涵盖测试和/或治疗性传播疾病、**AIDS**、**HIV**感染、酒精和/或药物滥用、心理健康状况或其他敏感信息。
Terms: This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

患者签名：_____ 日期/Date:_____
Patient Signature: （工整书写及手写签名）
(Print form and sign by hand)

患者代理人姓名：_____日期/Date:_____
Patient Representative Name:

患者代理人姓名： _____
Patient Representative Signature: （工整书写及手写签名。请附上证明文件。）
(Print form and sign by hand. Please include supporting documentation.)

与患者关系： _____
Relation to Patient: